

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **5061**

FILED JUN 9 1943

318

1003

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1-day**
In this community **50 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Stanley I. Parker**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None**

4. Sex **M.** 5. Color or Race **W.** 6. (a) Single, widowed, married, divorced **M.**

6. (b) Name of husband or wife **Veronica F. Parker** 6. (c) Age of husband or wife if alive **59** years

7. Birth date of deceased **Aug. 4th., 1879**
(Month) (Day) (Year)

8. AGE: Years **63** Months **9** Days **27** If less than one day _____ hr. _____ min.

9. Birthplace **Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Prop.**

11. Industry or business **House Furnishing**

12. Name **Unk. Parker** 13. Birthplace **England**
(City, town, or county) (State or foreign country)

14. Maiden name **Marie Ishawood** (State or foreign country)

15. Birthplace **England**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Thomas L. McLaughlin**
(b) Address **1035 Veronica Ave.**

17. (a) **Burial** (b) Date thereof **6-3-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Donnelly**
(b) Address **3840 Lindell Blvd.**

19. (a) **JUN 2 1943** (b) **J. J. Donnelly**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1035 Veronica Ave.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **31st.** year **1943** hour **3** minute **30** a. m.

21. I hereby certify that I attended the deceased from **May 31** to **May 31**, 19**43**
that I last saw him alive on **May 30**, 19**43**
and that death occurred on the date and hour stated above.
Immediate cause of death **Coronary heart disease**
Duration **3 years**

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **Coronary calcification**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **W. P. Hamilton** (M. D. or other) **MD**
Address **8363 Falls Ferry** Date signed **June 1-43**

St. John's Hospital 10 am.
Tuesday.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Stanley Marshall

Licensed Embalmer No.

2868

P. O. Address

3840 Lindeell

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.